

SECOND REGULAR SESSION
[TRULY AGREED TO AND FINALLY PASSED]
SENATE COMMITTEE SUBSTITUTE FOR
HOUSE BILL NO. 1473
91ST GENERAL ASSEMBLY

3762S.02T

2002

AN ACT

To repeal section 376.1350, RSMo, relating to health insurance, and to enact in lieu thereof two new sections relating to the same subject.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Section 376.1350, RSMo, is repealed and two new sections enacted in lieu thereof, to be known as sections 376.1350 and 376.1450, to read as follows:

376.1350. For purposes of sections 376.1350 to 376.1390, the following terms mean:

(1) "Adverse determination", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated;

(2) "Ambulatory review", utilization review of health care services performed or provided in an outpatient setting;

(3) "Case management", a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions;

(4) "Certification", a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness;

(5) "Clinical peer", a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review;

- 20 (6) "Clinical review criteria", the written screening procedures, decision abstracts,
21 clinical protocols and practice guidelines used by the health carrier to determine the necessity
22 and appropriateness of health care services;
- 23 (7) "Concurrent review", utilization review conducted during a patient's hospital stay or
24 course of treatment;
- 25 (8) "Covered benefit" or "benefit", a health care service that an enrollee is entitled under
26 the terms of a health benefit plan;
- 27 (9) "Director", the director of the department of insurance;
- 28 (10) "Discharge planning", the formal process for determining, prior to discharge from
29 a facility, the coordination and management of the care that a patient receives following
30 discharge from a facility;
- 31 (11) "Drug", any substance prescribed by a licensed health care provider acting within
32 the scope of the provider's license and that is intended for use in the diagnosis, mitigation,
33 treatment or prevention of disease. The term includes only those substances that are approved
34 by the FDA for at least one indication;
- 35 (12) "Emergency medical condition", the sudden and, at the time, unexpected onset of
36 a health condition that manifests itself by symptoms of sufficient severity that would lead a
37 prudent lay person, possessing an average knowledge of medicine and health, to believe that
38 immediate medical care is required, which may include, but shall not be limited to:
- 39 (a) Placing the person's health in significant jeopardy;
- 40 (b) Serious impairment to a bodily function;
- 41 (c) Serious dysfunction of any bodily organ or part;
- 42 (d) Inadequately controlled pain; or
- 43 (e) With respect to a pregnant woman who is having contractions:
- 44 a. That there is inadequate time to effect a safe transfer to another hospital before
45 delivery; or
- 46 b. That transfer to another hospital may pose a threat to the health or safety of the woman
47 or unborn child;
- 48 (13) "Emergency service", a health care item or service furnished or required to evaluate
49 and treat an emergency medical condition, which may include, but shall not be limited to, health
50 care services that are provided in a licensed hospital's emergency facility by an appropriate
51 provider;
- 52 (14) "Enrollee", a policyholder, subscriber, covered person or other individual
53 participating in a health benefit plan;
- 54 (15) "FDA", the federal Food and Drug Administration;
- 55 (16) "Facility", an institution providing health care services or a health care setting,

56 including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical
57 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory
58 and imaging centers, and rehabilitation and other therapeutic health settings;

59 (17) "Grievance", a written complaint submitted by or on behalf of an enrollee regarding
60 the:

61 (a) Availability, delivery or quality of health care services, including a complaint
62 regarding an adverse determination made pursuant to utilization review;

63 (b) Claims payment, handling or reimbursement for health care services; or

64 (c) Matters pertaining to the contractual relationship between an enrollee and a health
65 carrier;

66 (18) "Health benefit plan", a policy, contract, certificate or agreement entered into,
67 offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of
68 the costs of health care services; **except that, health benefit plan shall not include any**
69 **coverage pursuant to liability insurance policy, workers' compensation insurance policy,**
70 **or medical payments insurance issued as a supplement to a liability policy;**

71 (19) "Health care professional", a physician or other health care practitioner licensed,
72 accredited or certified by the state of Missouri to perform specified health services consistent
73 with state law;

74 (20) "Health care provider" or "provider", a health care professional or a facility;

75 (21) "Health care service", a service for the diagnosis, prevention, treatment, cure or
76 relief of a health condition, illness, injury or disease;

77 (22) "Health carrier", an entity subject to the insurance laws and regulations of this state
78 that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of
79 the costs of health care services, including a sickness and accident insurance company, a health
80 maintenance organization, a nonprofit hospital and health service corporation, or any other entity
81 providing a plan of health insurance, health benefits or health services; **except that such plan**
82 **shall not include any coverage pursuant to a liability insurance policy, workers'**
83 **compensation insurance policy, or medical payments insurance issued as a supplement to**
84 **a liability policy;**

85 (23) "Health indemnity plan", a health benefit plan that is not a managed care plan;

86 (24) "Managed care plan", a health benefit plan that either requires an enrollee to use,
87 or creates incentives, including financial incentives, for an enrollee to use, health care providers
88 managed, owned, under contract with or employed by the health carrier;

89 (25) "Participating provider", a provider who, under a contract with the health carrier or
90 with its contractor or subcontractor, has agreed to provide health care services to enrollees with
91 an expectation of receiving payment, other than coinsurance, co-payments or deductibles,

92 directly or indirectly from the health carrier;

93 (26) "Peer-reviewed medical literature", a published scientific study in a journal or other
94 publication in which original manuscripts have been published only after having been critically
95 reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and
96 that has been determined by the International Committee of Medical Journal Editors to have met
97 the uniform requirements for manuscripts submitted to biomedical journals or is published in a
98 journal specified by the United States Department of Health and Human Services pursuant to
99 section 1861(t)(2)(B) of the Social Security Act, as amended, as acceptable peer-reviewed
100 medical literature. Peer-reviewed medical literature shall not include publications or
101 supplements to publications that are sponsored to a significant extent by a pharmaceutical
102 manufacturing company or health carrier;

103 (27) "Person", an individual, a corporation, a partnership, an association, a joint venture,
104 a joint stock company, a trust, an unincorporated organization, any similar entity or any
105 combination of the foregoing;

106 (28) "Prospective review", utilization review conducted prior to an admission or a course
107 of treatment;

108 (29) "Retrospective review", utilization review of medical necessity that is conducted
109 after services have been provided to a patient, but does not include the review of a claim that is
110 limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding
111 or adjudication for payment;

112 (30) "Second opinion", an opportunity or requirement to obtain a clinical evaluation by
113 a provider other than the one originally making a recommendation for a proposed health service
114 to assess the clinical necessity and appropriateness of the initial proposed health service;

115 (31) "Stabilize", with respect to an emergency medical condition, that no material
116 deterioration of the condition is likely to result or occur before an individual may be transferred;

117 (32) "Standard reference compendia":

118 (a) The American Hospital Formulary Service-Drug Information; or

119 (b) The United States Pharmacopoeia-Drug Information;

120 (33) "Utilization review", a set of formal techniques designed to monitor the use of, or
121 evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services,
122 procedures, or settings. Techniques may include ambulatory review, prospective review, second
123 opinion, certification, concurrent review, case management, discharge planning or retrospective
124 review. Utilization review shall not include elective requests for clarification of coverage;

125 (34) "Utilization review organization", a utilization review agent as defined in section
126 374.500, RSMo.

376.1450. An enrollee, as defined in section 376.1350, may waive his or her right to

2 receive documents and materials from a managed care entity in printed form so long as
3 such documents and materials are readily accessible electronically through the entity's
4 Internet site. An enrollee may revoke such waiver at any time by notifying the managed
5 care entity by phone or in writing or annually. Any enrollee who does not execute such a
6 waiver and prospective enrollees shall have documents and materials from the managed
7 care entity provided in printed form. For purposes of this section, "managed care entity"
8 includes, but is not limited to, a health maintenance organization, preferred provider
9 organization, point of service organization and any other managed health care delivery
10 entity of any type or description.